BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
Nima Rezaei Abbassi, M.D.	)	**Case No. 800-2016-024524**
Physician's and Surgeon's Certificate No. A 131669	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 18, 2019.

IT IS SO ORDERED September 20, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: NIMA REZAEI ABBASSI, M.D. 9041 Magnolia Avenue, Suite 201 Riverside, California 92503-3955 Physician's and Surgeon's Certificate No. A 131669 Respondent.	Case No. 800-2016-024524 OAH No. 2018100444 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. Nima Rezaei Abassi, M.D. (Respondent) is represented in this proceeding by attorneys Dennis K. Ames, and Pogey Henderson whose address is: LaFollette, Johnson, DeHass, Fesler & Ames, located at 2677 North Main Street, Suite 901, Santa Ana, CA 92705-

6632.

3. On or about July 14, 2014, the Board issued Physician's and Surgeon's Certificate No. A 131669 to Respondent, Nima Rezaei Abbassi, M.D. That Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2016-024524, and will expire on September 30, 2019, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2016-024524 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on March 27, 2019. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2016-024524 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2016-024524. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent freely, voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended

Accusation No. 800-2016-024524, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 131669 issued to Respondent Nima Rezaie Abbassi, M.D., shall be and is hereby Publicly Reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient A as set forth in First Amended Accusation No. 800-2016-024524, is as follows:

1. On or about August 4, 2015 through February 27, 2016, in caring for Patient A, you: failed to document the manifest refraction of the patient's right eye on her first post-operative visit; incorrectly documented that the lens exchange was proposed for the right eye instead of the left eye; failed to document the patient's intraocular pressure from September 11, 2015 through December 17, 2015; failed to document the patient's visual acuity post-operatively following the intraocular lens exchange surgery on September 28, 2015; and failed to document the patient's signs and symptoms of dry eye, blepharitis and ptosis in the medical chart in violation of Business and Professions Code section 2266.

B. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 20 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

C. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem

pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to both the Continuing Medical Education (CME) requirements for renewal of licensure and the Education Course(s) required by Condition B above.

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys Dennis K. Ames, Esq. and Pogey Henderson, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. By entering into this Stipulation, I fully understand that, upon formal acceptance by the Board, I shall be publicly reprimanded by the Board and shall be required to comply with all of the terms and conditions of the Disciplinary Order set forth above and that any failure to comply with the terms and conditions herein shall constitute unprofessional conduct and will subject my Physician's and Surgeon's Certificate No. A 131669 to disciplinary action. With these understandings, I enter into this Stipulated Settlement and Disciplinary Order freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 3/29/19

NIMA REZAEI ABBASSI, M.D.
Respondent

I have read and fully discussed with Respondent, NIMA REZAEI ABBASSI, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 3/29/19

DENNIS K. AMES, ESQ.
POGEY HENDERSON, ESQ.
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 4/3/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2016-024524

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: NIMA REZAEI ABBASSI, M.D. 1595 East 17th Street Santa Ana, California 92705 Physician's and Surgeon's Certificate Number A 131669, Respondent.	Case No. 800-2016-024524 OAH No. 2018100444 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 14, 2014, the Medical Board issued Physician's and Surgeon's Certificate Number A 131669 to Nima Rezaei Abbassi, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2019, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2001.1 of the Code states:

"Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

5. Section 2227 of the Code states, in pertinent part:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, . . . , and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his . . . license revoked upon order of the board.

"(2) Have his . . . right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to

Section 803.1."

6. Section 2234 of the Code, states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, . . . any provision of this chapter.

"(b) . . . ."

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) . . . (h)."

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTUAL SUMMARY

8. Between February 2015 and March 2016, Respondent treated Patient A[1] as her ophthalmologist at Atlantis Eyecare. Patient A was an approximately 72-year-old woman who had been treated by an optometrist with Atlantis Eyecare for more than one year prior to Respondent's involvement in her care and treatment. Patient A had previously been diagnosed

[1] The patient herein is referred to as Patient A to protect her privacy.

with narrow angle glaucoma[2] and cataracts.[3] Over the course of the following year, Respondent treated Patient A at several Atlantis Eyecare locations in Southern California.

9. Patient A was initially referred to Respondent for a cataract evaluation due to worsening vision on February 17, 2015. Her visual acuity[4] was measured to be 20/60 in the right eye and 20/40 in the left eye. Respondent found that both of her eyes had significant nuclear sclerosis, which is characterized by clouding, hardening, and/or yellowing of the central region on the nucleus lens in the eye. At this point, Respondent mentioned the possibility of cataract surgery, but Patient A preferred to discuss the matter with her family first.

10. Respondent's next visit with Patient A took place on May 21, 2015. Patient A was complaining of "foggy vision" in both eyes and desired cataract surgery. Her visual acuity was measured to be 20/80 in the right eye and 20/40 in the left eye. Respondent recommended cataract extraction surgery with placement of an intraocular lens[5] in the right eye. Patient A accepted a premium lens package with a toric lens to be placed in the right eye.

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[2] Narrow Angle Glaucoma occurs when the colored portion of the eye is pushed or pulled forward causing a blockage of the drainage angle of the eye, where the trabecular meshwork allows outflow of fluids. As a result, the eye's intraocular pressure (IOP) may spike resulting in possible damage to the optic nerve that transmits images from the eye to the brain. Symptoms include eye pain, headaches, dilated pupils, red eyes, nausea, vomiting, and permanent vision loss. Narrow Angle Glaucoma is generally treated with oral or intravenous medications, as well as eye drops. In more serious cases, laser treatment or glaucoma surgery may be required to reduce IOP.

[3] A Cataract is a clouding of the lens in the eye which leads to a decrease in vision. Symptoms include faded colors, blurry vision, sensitivity to light, and increased difficulty with vision at night. Cataracts commonly occur due to aging, but they may also occur as a result of genetic disorders, trauma, diabetes, or complications after eye surgery for other problems. If conservative measures such as prescription eyeglasses fail to correct the patient's vision, cataract surgery may be utilized to remove the clouded lens and replace it with a clear artificial intraocular lens.

[4] Visual Acuity is the measure of the eyes' ability to distinguish object details and shape at a given distance. It is commonly measured using a numeric notating in which the numerator denotes the distance the patient is from a Snellen letter chart and the denominator denotes the distance at which an emmetropic eye could see the ototype on the chart. For example, a patient with visual acuity of 20/60 sees at twenty feet what the patient with no refractive error or ocular pathology would see at sixty feet.

[5] Intraocular Lenses (IOLs) are medical devices implanted inside the eye to replace the eye's natural lens when it is removed during cataract surgery. A toric IOL is a premium lens that corrects astigmatism, as well as nearsightedness and farsightedness. In contrast, a monofocal lens is designed to provide clear vision at a single focal point. Use of a monofocal lens will usually require the patient to use corrective glasses or contact lenses.

11. During this visit on May 21, 2015, Respondent noted in the medical records that Patient A's manifest refraction[6] was +3.50 -2.75 x080[7] in the right eye and +3.50 -1.75 x085 in the left eye, respectively. Pre-operative measurements of both eyes were taken by Respondent during this visit revealing that the axial length of her right eye was 21.13 millimeters, whereas the axial length of the left eye was 21.11 millimeters. Several measurements were also taken during this visit showing corneal cylinder (astigmatism) in Patient A's right eye that was greater than the left eye.[8] Utilizing the Intraocular Lens (IOL) Master, Patient A's corneal cylinder was measured to be -1.67D at 82 degrees in the right eye, and -0.30 at 77 degrees in the left eye. Utilizing corneal topography, Patient A's corneal cylinder was measured to be 1.22 at 175 degrees in the right eye, and 0.58 at a single digit axis in the left eye. Utilizing an autorefractor keratometer,[9] Patient A's corneal cylinder was measured to be 1.75 at 175 degrees in the right eye, and 0.75 at 5 degrees in the left eye. Despite the inconsistencies in these readings, there is no documentation of further investigation in Respondent's medical records for Patient A.

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[6] Manifest Refraction is the traditional method for measuring a patient's refractive error, which occurs when the eye doesn't bend light correctly (refract) as it enters the eye resulting in a blurred image. Ordinarily, a patient is seated in front of a phoropter device to determine the patient's need for lenses to correct refractive error. The patient is shown multiple images and asked to confirm the clearest image.

[7] The first number (+3.50) is the sphere power in diopters for the correction of nearsightedness (myopia) in the flatter principal meridian of the eye. The second number (-2.75) is the cylinder power for the additional myopia correction required for the more curved principal meridian. The third number (080) is called the axis of astigmatism. This is the location in degrees of the flatter principal meridian on a 180-degree rotary scale, where 90 degrees designates the vertical meridian of the eyes, and 180 degrees designates the horizontal meridian.

[8] Astigmatism is a refractive error in which light that enters the eye fails to come to a single focus on the retina to produce clear vision. Instead, multiple focus points occur either in front of the retina or behind it, or both. Astigmatism causes blurred or distorted vision for the patient to some degree at all distances. Astigmatism is usually caused by an irregularly shaped cornea, instead of the cornea having a symmetrically round shape. Manual refraction is one preliminary test, in addition to an eye exam, that an optometrist or ophthalmologist can use to determine the presence and extent of astigmatism in a patient. Astigmatism can usually be corrected with eyeglasses, contact lenses, or refractive surgery.

[9] An autorefractor keratometer (Auto-K) is a device used to measure the degree of refractive error in a patient's eye as light reflects through the eyeball. It is often used to determine an individual's corrective lens prescription, differentiate between corneal from lenticular aberrations, and assessing pre-operative and post-operative refractive surgery patients. Typically, the patient will focus their vision on a fixation target, such as a hot air balloon floating over land, while the device takes spherical and cylindrical measurements ranges.

12. On July 27, 2015, Patient A underwent the first cataract extraction with placement of a toric lens implant in her right eye. The surgery was completed successfully without complication or further incident. One day after surgery, Patient A's visual acuity was noted to be 20/100 in the right eye with a clear cornea documented.

13. On August 4, 2015, Patient A returned to Respondent for a post-operative visit. Patient A's visual acuity improved to 20/80 in the right eye. However, Respondent did not perform or document manifest refraction of Patient A's right eye to determine how far off target the surgical result was and how to avoid myopia[10] with the planned cataract extraction and lens placement for the left eye.

14. On August 17, 2015, Patient A underwent the second cataract extraction with placement of a monofocal lens implant in the left eye. The surgery was completed successfully without complication or further incident. One day after surgery, Patient A's visual acuity was noted to be 20/100 in the right eye and 20/80 in the left eye.

15. On August 25, 2015, Patient A returned to Respondent for a post-operative visit complaining of worsening vision. Patient A's visual acuity was measured as 20/200 in each eye with a manifest refraction of -1.75 DS 20/25 in the right eye and -1.25 DS 20/25 in the left eye. During this visit with Patient A, Respondent discussed the possibility of a lens exchange in her left eye, although Respondent's medical records incorrectly listed that the lens exchange was proposed for the right eye.

16. On September 3, 2015, Patient A was seen by an optometrist at Atlantis Eyecare. Her visual acuity was measured to be 20/200 in both eyes. Patient A's manifest refraction was measured to be -2.25 in the right eye and -1.00 -1.25 x 095 in the left eye. Patient A's autorefractor keratometer readings were an average of 45.25 in the right eye and 44.75 in the left eye, respectively.

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[10] Myopia is commonly referred to a "nearsightedness." It is the most common refractive error of the eye. Patients with myopic vision will have difficulty seeing distant objects, but otherwise have average vision when conducting close-up tasks such as reading.

17. Respondent next saw Patient A on September 11, 2015. Patient A's visual acuity was measured to be 20/100 in the right eye and 20/80 in the left eye. Respondent noted that Patient A had a cycloplegic refraction[11] of -1.50 +0.50 x180 in the right eye, as well as -1.75 +1.25 x180 in the left eye. At this visit, Patient A decided to exchange the monofocal lens in her left eye for a toric lens instead.

18. On September 22, 2015, measurements were again taken regarding the corneal cylinder (astigmatism) in Patient A's eyes. Utilizing the IOL Master, Patient A's corneal cylinder was measured to be -1.67D at 82 degrees in the right eye and -0.30 at 77 degrees in the left eye. Utilizing the IOL Master, Patient A's corneal cylinder was measured to be -1.69 at 79 degrees in the right eye and -0.49D at 98 degrees in the left eye. A second corneal topography was not performed or documented in the medical records.

19. On September 28, 2015, Patient A underwent an intraocular lens exchange. During removal of the monofocal lens in Patient A's left eye, however, the corneal incision tore creating a corneal laceration. Respondent proceeded to implant a toric lens and placed five sutures to close the corneal incision. Respondent disclosed the surgical complication to Patient A after the surgery, although her post-operative visual acuity was not recorded the day after surgery. Additionally, Respondent's operative note did not indicate markings were done for a toric intraocular lens implant.

20. Between September 2015 and December 2015, Patient A visited the Respondent approximately eleven times, excluding the surgery on September 28, 2015. Patient A was placed on prednisolone steroid to be taken every hour from September 29, 2015, until October 22, 2015. However, Patient A's intraocular pressure was not recorded during the following clinical visits: September 11, 2015; September 29, 2015; October 1, 2015; October 8, 2015; October 15, 2015; October 29, 2015; and December 17, 2015. Additionally, Patient A's visual acuity was not documented in any of the post-operative visits following the intraocular lens exchange surgery on

[11] A cycloplegic refraction is a specialized eye exam procedure used to determine a patient's complete refractive error by temporarily paralyzing the muscles that aid in focusing the eye. Cycloplegic eye drops are used to temporarily paralyze or relax the focusing muscle (ciliary body) of the eye. This procedure is utilized to determine the full refractive error of the patient without any influence from the patient, such as sub-consciously over focusing on distant objects.

September 28, 2015. Moreover, Patient A's refraction was not measured again until February 27, 2016.

21. On January 28, 2016, Patient A visited Respondent for a procedure to remove the corneal incision sutures. During this visit, Respondent learned that Patient A's intraocular pressure had not been recorded in the medical records for the previous visits between September 2015 and December 2015. Respondent noted in the medical records that in "reviewing old notes it came to my attention that [intraocular pressure] was not noted for some visits...each visit she has benn [sic] between 10-12." However, Respondent did not correct the previous medical entries. In addition, Respondent's chart entry for this visit did not document refractions or corneal topography utilized to help guide suture removal.

22. On February 27, 2016, Respondent saw Patient A whose refraction in the left eye was measured to be -1.25 -4.50 x030. That same day Patient A underwent a YAG laser capsulotomy[12] procedure, which was done by Respondent. Ultimately, the patient grew dissatisfied with her vision after the three surgeries between August and September 2015. Consequently, she left Respondent's treatment at Atlantis Eyecare after her final visit on March 31, 2016. Patient A continued her care with an ophthalmologist at Kaiser Permanente.

23. Respondent's medical records for Patient A did not indicate the lens power or model with regards to Patient A's cataract extraction and lens placement surgeries in July and August 2015, as well as the intraocular lens exchange in September 2015. Furthermore, Respondent's chart notes did not document the appearance of Patient A's corneas. Signs or symptoms of dry eye, blepharitis, and ptosis were not documented in Respondent's medical records for Patient A. Lastly, nearly all of Respondent's visit notes in Patient A's medical record were not electronically signed by him until May 26, 2016.

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[12] YAG capsulotomy is an outpatient laser treatment procedure that is used to improve a patient's vision after cataract surgery. During cataract surgery, the natural lens inside of the patient's eye is removed and an intraocular lens is inserted into the lens membrane, which is referred to as the bag or capsule. Some patients experience thickening of the capsule after cataract surgery. An opthalmologist will use a special lens to apply a laser beam to the capsule thereby creating a small hole in the center of the capsule, which allows light through. If successful, this laser treatment will remove the cloudy capsule thickening in the patient's eye and restore his or her vision to how it was after the cataract surgery.

STANDARD OF CARE

24. **Astigmatism Management.** The community standard of care for an opthalmologist is to ensure that refraction is stable before recommending any surgical intervention for astigmatism. It is also the standard of care to offer a patient toric lenses based off of corneal cylinder, as opposed to refractive cylinder. Moreover, the standard of care is to use autorefractor keratometer readings from optic biometry or manual keratometry readings in toric lens calculators. Corneal topography is used to check that astigmatism is regular and that the axis is in agreement. Finally, if there is greater astigmatism after cataract surgery with a monofocal lens implant than predicted by pre-operative measurements, then the standard of care is to do a careful investigation of possible causes such as: tilt of the implant; surgically induced astigmatism; ocular surface disease; and anterior basement membrane disease.

25. **Pre-Operative Evaluation Before Cataract Surgery.** The community standard of care for an opthalmologist is to perform manifest refraction on the patient's first eye that was previously operated on before proceeding with cataract surgery on the patient's second eye. Performing manifest refraction allows a surgeon to determine how close to target their initial lens choice came for the patient's first eye. This further allows the surgeon to make adjustments when choosing the lens implant, if needed, for the patient's second eye.

26. **Medical Record Keeping.** The community standard of care in medical practice is to document examinations accurately and to document medically important conversations with the patient. A documented discussion of reasons for refractive error should also include the following options to address refractive error: eyeglasses; contact lenses; refractive laser surgery; limbal relaxing incisions; and intraocular lens exchange. It is also the standard of care for a physician to review everything that a scribe and/or technician enters or fails to enter into a chart and to correct the chart, if necessary. Corrections to the patient's medical chart should be made on or near the date of service before the encounter is closed. Furthermore, the standard of care requires a physician to sign notes or close encounters within an electronic medical record within a reasonable timeframe from the date of service. Finally, the standard of care requires that a physician know how to complete notes within the electronic medical record system he or she

utilizes.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

27. Respondent's license is subject to disciplinary action under Section 2234, subdivision (c) of the Code, in that Respondent committed repeated negligent acts during his care and treatment of Patient A. The circumstances are as follows:

28. Complainant refers to and, by this reference, incorporates paragraphs 8 through 26 above, as though fully set forth herein.

29. The following acts and omissions, considered individually and collectively, constitute repeated negligent acts in Respondent's practice as a physician and surgeon:

A. Recommending and performing a surgery that may not have been indicated given that Respondent ultimately implanted a toric lens in Patient A's left eye despite a low level of corneal cylinder as measured by the IOL Master and corneal topography.

B. Failing to check the refractive result of Patient A's right eye before planning and proceeding with the second cataract extraction and lens placement procedure for her left eye.

C. Failing to diligently document exam findings and care provided to Patient A in the medical records.

SECOND CAUSE FOR DISCIPLINE

(Inadequate and/or Inaccurate Record-Keeping)

30. By reason of the facts set forth in paragraphs 8 through 23 and 26 above, Respondent's license is further subject to disciplinary action under Section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records relating to his provision of services to Patient A.

31. Respondent's acts and/or omissions as set forth in paragraphs 8 through 23 and 26 above, whether proven individually, jointly, or in any combination thereof, constitute Respondent's failure to maintain adequate and accurate records relating to his provision of services to Patient A, pursuant to Section 2266 of the Code.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

32. By reason of the facts set forth in paragraphs 8 through 26 above, Respondent is subject to disciplinary action under Section 2234, subdivision (a) of the Code, in that Respondent has engaged in unprofessional conduct based upon his repeated negligent acts, and his failure to maintain adequate and accurate records relating to his provision of services to Patient A.

33. Respondent's acts and/or omissions as set forth in paragraphs 8 through 26 above, whether proven individually, jointly, or in any combination thereof, constitute Respondent's unprofessional conduct based upon repeated negligent acts, and his failure to maintain adequate and accurate records relating to his provision of services to Patient A, pursuant to Section 2234, subdivision (a) of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 131669, issued to Nima Rezaei Abbassi, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to Section 3527 of the Code, and advanced practice nurses;

3. If placed on probation, ordering Nima Rezaei Abbassi, M.D. to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: 3/26/2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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